



STATE OF MISSOURI  
DEPARTMENT OF INSURANCE  
**MEDICARE SUPPLEMENT RATE FILING DOCUMENT**

<b>COMPANY INFORMATION</b>		<b>POLICY RATE/PREMIUM INFORMATION</b>	
Company Name:		Original Filed Loss Ratio: %	
NAIC Company Code (9 digits):		Rate Change Requested: %	
Domicile State:		Effective Period (expected): ____/____/____ - ____/____/____ (these dates may change based on the approval date)	
Date of this Filing:		Premium Rating Basis (if mixed, check all that apply):	
<b>POLICY FORM INFORMATION</b>		<input type="checkbox"/> Issue Age	
		<input type="checkbox"/> Attained Age	
		<input type="checkbox"/> Community Rated	
		Number of Missouri Rating Areas:	
		List Rate Filings in Missouri in Last 5 Years: (list most recent first)	
Policy Form Number(s):		Approved (mo/yr)      Implemented (mo/yr)      Rate Change Approved (%)	
Plan Type (check one):		<input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/> %	
Standardized Plans:		<input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/> %	
<input type="checkbox"/> Plan A <input type="checkbox"/> Plan F		<input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/> %	
<input type="checkbox"/> Plan B <input type="checkbox"/> Plan G		<input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/> %	
<input type="checkbox"/> Plan C <input type="checkbox"/> Plan H		<input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/> %	
<input type="checkbox"/> Plan D <input type="checkbox"/> Plan I		<input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/> %	
<input type="checkbox"/> Plan E <input type="checkbox"/> Plan J		<input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/> %	
Pre-Standardized Plans:		<b>POLICY DATA</b>	
<input type="checkbox"/> One Policy Form			
<input type="checkbox"/> Pooled Policy Forms			
Plan Type (check one):			
<input type="checkbox"/> Individual <input type="checkbox"/> Indiv. Select			
<input type="checkbox"/> Group <input type="checkbox"/> Group Select		Missouri      National	
Marketing Method (check one):		Policy Approved in (year)	
<input type="checkbox"/> Agent Sold <input type="checkbox"/> Dir. Response		First Policy Issued in (year)	
<input type="checkbox"/> Conversion <input type="checkbox"/> Assumption		Last Policy Issued in (year)*	
Underwriting Method (excl. open enrollment) (check one):		Policy Withdrawn in (year)*	
<input type="checkbox"/> Guar. Issue <input type="checkbox"/> Underwritten		Number of Aged Insureds	
Eligibility (check all that apply):		Number of Disabled Insureds	
<input type="checkbox"/> Age 65 & Over <input type="checkbox"/> Disabled		Number of Total Insureds	
<b>ACTUARIAL CERTIFICATION</b>		Insured Data as of: ____/____/____	
		*-If still being issued, state "Current"	
		I hereby certify that to the best of my knowledge and ability, the following are true with respect to this filing:	
		1. The assumptions present the actuary's best judgment as to the expected value for each assumption and are consistent with the issuer's business plan at the time of the filing.	
		2. The anticipated lifetime, future, and third-year loss ratios all comply with the regulatory loss ratio requirements. For pre-standardized plans, the 1996-and-later (SSA-94) loss ratio also complies with the regulatory loss ratio requirements.	
3. The filed rates maintain the proper relationship between policies which have different rating methodologies (if such exist).			
4. The filing was prepared based on the current standards of practice as promulgated by the Actuarial Standards Board.			
5. The filing is in compliance with applicable laws and regulations in the state.			
6. The rates requested are reasonable in relationship to the benefits provided.			
Actuary's Signature: _____			
Actuary's Name (print), including actuarial accreditations: _____			
Date Signed: _____			